

Your summary of benefits



Anthem® Blue Cross

Your 2026 Contract Code: 901V

Your Plan: Anthem Platinum Select HMO 25

Your Network: Select HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental health and substance use disorders. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$50 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$0 person / \$0 family	Not covered
Overall Out-of-Pocket Limit <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>	\$2,300 person / \$4,600 family	Not covered
<i>The family out-of-pocket limit is embedded, meaning each covered person is capped at his or her per member out-of-pocket limit; in addition, cost shares for all covered family members apply to the family out-of-pocket limit, yet no one member will pay more than the per member out-of-pocket limit.</i>		
<i>Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.</i>		
Doctor Visits (virtual and office) <i>Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$25 copay per visit	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Provider <i>virtual and office</i>	\$50 copay per visit	Not covered
Other Practitioner Visits Maternity Doctor services Prenatal care Delivery Postpartum care Retail Health Clinic Visit Chiropractic/Manipulation Therapy <i>Coverage is limited to 30 visits per year.</i> Acupuncture	No charge No charge \$25 copay per visit \$25 copay per visit \$15 copay per visit \$25 copay per visit	Not covered Not covered Not covered Not covered Not covered Not covered
Other Services in an Office Allergy Testing Prescription Drugs - Dispensed in the office <i>For the drugs itself dispensed in the office through infusion/injection.</i> Surgery	\$25 copay per visit \$125 copay per day \$50 copay per surgery	Not covered Not covered Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
Diagnostic Services Lab Office <i>Office Cost Share applies only when Freestanding/Reference Labs are not used.</i> Freestanding Lab/Reference Lab Outpatient Hospital	\$10 copay per day No charge \$15 copay per day	Not covered Not covered Not covered
Diagnostic Services X-Ray Office Freestanding Radiology Center	\$10 copay per day \$10 copay per visit	Not covered Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	\$30 copay per day	Not covered
<p><u>Diagnostic Services Advanced Diagnostic Imaging</u> - for example: MRI, PET and CAT scans</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$100 copay per day</p> <p>\$100 copay per day</p> <p>\$250 copay per day</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care (Office Setting)</p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance Transportation</p>	<p>\$25 copay per visit</p> <p>\$275 copay per visit</p> <p>No charge</p> <p>\$150 copay per trip</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$150 copay per visit</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services including surgeon fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>\$200 copay per visit</p> <p>\$150 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u> <i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i></p>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>Facility fees (for example, room & board) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i></p> <p>Physician and other services including surgeon fees</p>	<p>\$300 copay per day up to 3 days per admission</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Home Health Care</u> <i>Home health visits are limited to 100 visits per benefit period. Benefit limit does not apply to physical, occupational or speech therapy when performed as part of Home Health. Limits are combined for home health care and private duty nursing.</i></p>	<p>\$50 copay per visit</p>	<p>Not covered</p>
<p><u>Therapy Services</u></p> <p>Rehabilitation services (for example, physical/speech/occupational therapy)</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p>Habilitation services (for example, physical/speech/occupational therapy)</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p>Pulmonary rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>\$50 copay per visit</p>	<p>Not covered</p> <p>Not covered</p>
<p>Dialysis/Hemodialysis office and outpatient hospital</p>	<p>\$50 copay per visit</p>	<p>Not covered</p>
<p>Chemo/Radiation Therapy office and outpatient hospital</p>	<p>\$50 copay per visit</p>	<p>Not covered</p>
<p>Skilled Nursing Care (in a facility) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 100 days combined per benefit period.</i></p>	<p>\$100 copay per day up to 3 days per admission</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	50% coinsurance	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
<p>Prescription Drug Coverage Network: Rx Choice Tiered Network Drug List: Select Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.</p>			
<p>Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (cost shares noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</p>			
<p>Tier 1 - Typically Generic Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</p>	\$5 copay per prescription (retail) and \$10 copay per prescription (home delivery)	\$15 copay per prescription (retail only)	Not covered (retail and home delivery)
<p>Tier 2 - Typically Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</p>	\$20 copay per prescription (retail) and \$50 copay per prescription (home delivery)	\$30 copay per prescription (retail only)	Not covered (retail and home delivery)
<p>Tier 3 - Typically Non-Preferred Brand Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</p>	\$50 copay per prescription (retail) and \$125 copay per prescription (home delivery)	\$60 copay per prescription (retail only)	Not covered (retail and home delivery)
<p>Tier 4 - Typically Specialty (brand and generic)</p>	30% coinsurance up to \$250 per prescription (retail and home delivery)	40% coinsurance up to \$250 per prescription (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.</i></p>		
<p>Children's Vision Essential Health Benefits (up to age 19)</p>		
<p>Child Vision Deductible</p> <p>Vision Exam <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not applicable No charge</p>	<p>Not applicable Not covered</p>
<p>Frames <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Single Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Bifocal Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Trifocal Vision Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Elective Contact Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Non-Elective Contact Lenses <i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Adult Vision (age 19 and older)</p>		
<p>Adult Vision Deductible</p> <p>Vision Exam <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i></p>	<p>Not applicable \$20 copay</p>	<p>Not applicable Not covered</p>
<p>Frames</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Single Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Bifocal Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Trifocal Vision Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Elective Contact Lenses</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Non-Elective Contact Lenses</p>	<p>Not covered</p>	<p>Not covered</p>

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><i>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.</i></p>		
Children's Dental Essential Health Benefits		
Diagnostic and preventive <i>Coverage for In-Network Providers is limited to 1 visit per 6 months.</i>	No charge	Not covered
Basic services	20% coinsurance	Not covered
Major services	50% coinsurance	Not covered
Medically Necessary Orthodontia services	50% coinsurance	Not covered
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	\$0	Not covered
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Notes:

- Benefit period refers to calendar year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a “Summary of Benefits and Coverage”.
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider’s charge.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Certain services are subject to the utilization review program or precertification. Before scheduling services, the member must make sure utilization or precertification review is obtained. If utilization or precertification review is not obtained, benefits may be reduced or not paid according to the plan.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Questions: (833) 913-2234 or visit us at www.anthem.com/ca

CA/SG/Anthem Platinum Select HMO 25/901V/2026

Get help in your language

Language Assistance Services

Curious to know what all this says?

We would be too. Here's the English version: IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD:711)

Separate from our language assistance program, we make documents available in alternative formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos pedirle a alguien que le ayude a leerla. También es posible que pueda solicitar que le enviemos esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721 (TTY/TDD: 711).

Arabic

هام: هل تستطيع قراءة هذه الرسالة؟ إذا لم يكن الأمر كذلك، يمكننا أن نطلب من شخص ما مساعدتك في قراءتها. قد تتمكن أيضاً من الحصول على هذه الرسالة مكتوبة بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال على الفور على الرقم 1-888-254-2721. (TTY/TDD: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք կարդալ այս նամակը: Եթե ոչ, մենք կարող ենք առաջարկել որևէ մեկի օգնությունը՝ ձեզ համար այն կարդալու համար: Դուք կարող եք նաև այս նամակը ստանալ ձեր լեզվով: Անվճար օգնության համար խնդրում ենք անմիջապես զանգահարել՝ 1-888-254-2721. (TTY/TDD: 711)

Chinese

重要：您能看此信嗎？如果不能，我們可以請人幫您看。您還可以獲得以您的語言寫的此信件。如需免費幫助，請立即致電 1-888-254-2721. (TTY/TDD:711)

Farsi

ما، توانیدمی اگر بخوانید؟ را نامه این توانید می آیا مهم کند کمک شما به آن خواندن در خواهیم شخصی از توانیممی زبان به و کتبی صورت به را نامه این بتوانید است ممکن همچنین با فوراً لطفاً، رایگان کمک دریافت برای. کنید دریافت خودتان تماس (TTY/TDD: 711) 1-888-254-2721 شماره بگیرید.

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में किसी की मदद ले सकते हैं। यह पत्र आप अपनी भाषा में भी लिखवा सकते हैं। निःशुल्क सहायता के लिए, कृपया तुरंत 1-888-254-2721 पर कॉल करें। (टीटीवाई/टीडीडी:711)

Hmong

TSEEM CEEB: Koj puas nyeem tau daim ntawv no? Yog tias tsis tau, peb muaj qee tus neeg pab nyeem nws rau koj. Koj los kuj yuav tau txais ib daim ntawv sau ua kom yam lus. Rau kev pab dawb, thov hu tam sim ntawm 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この文書を読むことができますか？読むことができない場合、支援することが可能です。また、日本語で訳されたこの文書を書面で受け取ることができます。無料の支援をご希望の場合、1-888-254-2721 (TTY/TDD:711) にご連絡ください。

Khmner

សំខាន់៖ តើអ្នកអាចអានសំបុត្រនេះបានទេ? បើអត់ទេ យើងអាចមានអ្នកជួយអាន។ អ្នកក៏អាចទទួលបានសំបុត្រនេះសរសេរជាភាសា របស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយ ឥតគិតថ្លៃ សូមទូរស័ព្ទមកភ្លាមៗតាមរយៈលេខ 1-888-254-2721. (TTY/TDD: 711)

Korean

중요: 이 편지를 읽으실 수 있으신가요?
 그렇지 않으신 경우, 이를 읽으실 수 있도록
 도움을 제공해 드릴 수 있습니다. 귀하의
 모국어로 된 편지를 우편으로 받아보실 수도
 있습니다. 무상으로 제공되는 도움이
 필요하신 경우, 1-888-254-2721번으로 바로
 연락해 주십시오. (TTY/TDD: 711)

Punjabi

ਕੀ ਤੁਸੀਂ ਇਹ ਚਿੱਠੀ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇਕਰ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ
 ਇਸਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ
 ਇਸ ਚਿੱਠੀ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖ ਸਕਦੇ ਹੋ।
 ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਤੁਰੰਤ ਇਸ 'ਤੇ ਕਾਲ
 ਕਰੋ 1-888-254-2721। (TTY/TDD: 711)

Russian

ВАЖНАЯ ИНФОРМАЦИЯ: Можете ли
 вы прочитать данное письмо? Если нет,
 наш специалист поможет вам в этом.
 Вы также можете получить данное
 письмо на вашем языке. Для получения
 бесплатной помощи звоните по номеру
 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Mababasa mo ba ang
 sulat na ito? Kung hindi, mayroon kaming
 makakatulong sa iyo na basahin ito.
 Maaari mo ring makuha ang sulat na ito
 nang nakasulat sa iyong wika. Para sa
 libreng tulong, mangyaring tumawag
 kaagad sa 1-888-254-2721.
 (TTY/TDD: 711)

Thai

สำคัญ: คุณสามารถอ่านจดหมายนี้ได้หรือไม่
 หากคุณอ่านจดหมายนี้ไม่ได้ เราสามารถขอให้
 ใครสักคนช่วยคุณอ่านได้ คุณสามารถร้องขอ
 จดหมายนี้ที่เขียนในภาษาของคุณได้เช่นกัน
 หากต้องการความช่วยเหลือแบบไม่มีค่าใช้จ่าย
 โปรดโทรหาเราได้ทันทีที่ 1-888-254-2721.
 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có đọc được lá thư
 này không? Nếu không, chúng tôi có thể
 nhờ ai đó giúp quý vị đọc. Quý vị cũng có
 thể yêu cầu thư này viết bằng ngôn ngữ
 của quý vị. Để được trợ giúp miễn phí,
 hãy gọi ngay đến số 1-888-254-2721.
 (TTY/TDD: 711)

It's important we treat you fairly

We follow state and federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services, in a timely manner, like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or if you think you were discriminated against based on race, color, national origin, age, disability, or sex, you can mail a complaint directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>